UNITED CONCORDIA
America's Premier Dental Insurer

Please send to:

Attn: Joel Hardyk
Fax: 1-800-329-9093
or
Dependent Certification
United Concordia Companies
PO Box 69417
Harrisburg PA 17106-9417

DEPENDENT CERTIFICATION FORM

Please complete Sections A and B, C or D of this form as applicable to ensure that accurate benefit eligibility is determined for your dependent.

SECTION A: GENERAL INFORMATION *(To be completed by Employee)*

1. Name of Employee (print - last, first & middle initial)

2. Contract ID Number

3. Employee's Address (number, street, city, state & zip code)

4. Dependent Name (print - last, first & middle initial)

5. Dependent's Birthdate (mm/dd/year)

6. Dependent's Relationship to Employee
☐ Son ☐ Daughter ☐ Other

7. Dependent's Marital Status
☐ Single ☐ Married

If dependent is married, give date of marriage (mm/dd/year)

8. Is dependent currently covered under employee's medical group coverage?
☐ Yes ☐ No

If Yes, give name of carrier

9. Is dependent employed?
☐ Yes ☐ No

If yes,
☐ Full-Time ☐ Part-Time ☐ School Vacation Period Only

SECTION B: STUDENT DEPENDENT CERTIFICATION *(To be completed by Employee)*

1. Name of school in which dependent is enrolled

2. Type of school (i.e., college, trade etc.)

3. Student enrolled
☐ Full-Time ☐ Part-Time ☐ Post-Graduate _____ Number of Credits

4. Expected graduation or disenrollment date (mm/dd/year)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Employee _____ Date Signed _____

SECTION C: DISABLED DEPENDENT CERTIFICATION *(To be completed by Physician)*

1. Is dependent now incapable of self-support because of a disability?
☐ Yes ☐ No

2. Dependent's age when disability occurred

3. Nature of disability (please provide as much detail as possible)

4. Prognosis (estimate in months or years)

5. Name of Primary Care Physician (print or type)

6. Address of Physician (print or type)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO THIS CERTIFICATION.

Signature of Physician _____ Date Signed _____

SECTION D: DEPENDENT NO LONGER ELIGIBLE *(To be completed by Employee)*

PLEASE MAKE INQUIRY WITH YOUR EMPLOYER TO DETERMINE IF YOUR INELIGIBLE DEPENDENT QUALIFIES FOR COBRA COVERAGE.

I ACKNOWLEDGE THAT THE DEPENDENT LISTED ABOVE IS NO LONGER ELIGIBILE FOR BENEFITS AS A DEPENDENT ON MY UNITED CONCORDIA DENTAL CONTRACT.

Signature of Employee _____ Ineligible Effective Date _____ Date Signed _____